UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

IN RE: NATIONAL PRESCRIPTION OPIATE LITIGATION	)	MDL No. 2804
_____	)	Case No. 1:17-MD-2804
THIS DOCUMENT RELATES TO ALL CASES	)	Hon. Dan A. Polster

THURSDAY, JUNE 13, 2019

HIGHLY CONFIDENTIAL – SUBJECT TO FURTHER CONFIDENTIALITY REVIEW

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Videotaped deposition of Gerard Hevern, M.D., held at the offices of Dechert LLP, 100 Oliver Street, 40th Floor, Boston, Massachusetts, commencing at 9:04 a.m., on the above date, before Carrie A. Campbell, Registered Diplomate Reporter and Certified Realtime Reporter.

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GOLKOW LITIGATION SERVICES
877.370.3377 ph | 917.591.5672 fax
deps@golkow.com

A P P E A R A N C E S :

KELLER ROHRBACK LLP
BY: DEAN KAWAMOTO
dkawamoto@kellerrohrback.com
ALISON GAFFNEY
agaffney@kellerrohrback.com
1201 Third Avenue, Suite 3200
Seattle, Washington 98101
(206) 623-1900

SIMMONS HANLY CONROY LLC
BY: SANFORD SMOKLER
ssmokler@simmonsfirm.com
(VIA REALTIME STREAM)
112 Madison Avenue, Seventh Floor
New York, New York 10016
(212) 784-6400

BARON & BUDD P.C.
BY: JAY LICHTER
Jlichter@baronbudd.com
(VIA REALTIME STREAM)
15910 Ventura Boulevard, Suite 1600
Encino, California 91436
(818) 839-2333
Counsel for Plaintiffs

DECHERT LLP
BY: TIMOTHY C. BLANK
timothy.blank@dechert.com
NEGIN HADAGHIAN
negin.hadaghian@dechert.com
100 Oliver Street, 40th Floor
Boston, Massachusetts 02110
(617) 728-7100
Counsel for Purdue Pharma

O'MELVENY & MYERS LLP
BY: MATTHEW T. MURPHY
mtmurphy@omm.com
(VIA TELECONFERENCE)
7 Times Square
New York, New York 10036
(212) 326-2000
Counsel for Johnson & Johnson and Janssen

CAVITCH FAMILO & DURKIN, CO., L.P.A.
BY: ROBERT WEST
rwest@cavitch.com
(VIA TELECONFERENCE)
1300 East 9th Street
Cleveland, Ohio 44114
(216) 621-7860
Counsel for Discount Drug Mart

BAILEY WYANT PLLC
BY: JUSTIN TAYLOR
jtaylor@baileywyant.com
(VIA REALTIME STREAM)
500 Virginia Street East, Suite 600
Charleston, West Virginia 25301
(304) 345-4222
Counsel for West Virginia Board of Pharmacy

VIDEOGRAPHER:
ROBERT SWEIG,
Golkow Litigation Services

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(Exhibits attached to the deposition.)

VIDEOGRAPHER: We are now on the record.

My name is Robert Sweig, and I am a videographer representing Golkow Litigation Services.

Today's date is June 13, 2019, and the time is 9:04 a.m.

This video deposition is being held in Boston, Massachusetts, in the matter of In Re: National Prescription Opiate Litigation, pending before the United States District Court for the Northern District of Ohio, Eastern Division.

Our deponent is Gerard Hevern, MD.

Would counsel attending locally please identify yourselves for the record?

MS. GAFFNEY: Alison Gaffney from Keller Rohrback for the plaintiffs.

MR. KAWAMOTO: Dean Kawamoto, Keller Rohrback, for the plaintiffs.

MR. BLANK: Tim Blank with

Dechert for defendant Purdue.

MS. HADAGHIAN: Negin Hadaghian from Dechert, also for defendant Purdue.

VIDEOGRAPHER: Thank you.

And would counsel attending via teleconference please identify yourselves for the record?

MR. MURPHY: Matthew Murphy from O'Melveny & Myers on behalf of Johnson & Johnson and Janssen.

MR. WEST: Robert West on behalf of Discount Drug Mart.

VIDEOGRAPHER: All right. Thank you.

Our court reporter is Carrie Campbell, and she will now swear in our witness.

GERARD HEVERN, M.D.,

of lawful age, having been first duly sworn to tell the truth, the whole truth and nothing but the truth, deposes and says on behalf of the Plaintiffs, as follows:

DIRECT EXAMINATION

QUESTIONS BY MS. GAFFNEY:

Q. Good morning, Dr. Hevern.

Could you please state and spell your full name for the record?

A. Sure. My name is Gerard Hevern, G-e-r-a-r-d, last name Hevern, H-e-v-e-r-n.

Q. Thank you.

Have you ever been known by any other names?

A. Jerry, J-e-r-r-y.

Q. Thank you.

Dr. Hevern, you understand you're under oath today, right?

A. I do.

Q. Is there any reason that you would be unable to give your full, complete and honest testimony today?

A. No.

Q. Not on any medication that would interfere with your ability to testify today?

A. I'm not.

Q. Okay. Have you ever testified

in a deposition or trial or legal proceeding before?

A. Yes, I have.

Q. Okay. And we'll go back to that later, but so I presume you're familiar with the ground rules of depositions. There's just a few I'd like to go over.

First is that we not speak over each other for the sake of the record, the court reporter, so please wait for me to finish asking a question before you answer, and I will wait for you to finish answering before I ask another question.

Second is that when you answer a question, please answer it verbally, not nodding or shaking the head.

And then last, if I ask a question that you don't understand, just let me know and I will try to rephrase it.

Sound good?

A. Sounds fine.

(Hevern Exhibit 1 marked for identification.)

QUESTIONS BY MS. GAFFNEY:

Q. Okay. Great.

I would like to mark as Exhibit 1 the notice of deposition.

A. Do I hand this back to you or --

Q. No, that's your copy.

Have you seen this document before?

A. I have.

Q. Okay. And you've reviewed this notice, I take it?

A. I have.

Q. Okay. Did you bring any materials with you to the deposition today?

A. No, I have not.

Q. Okay. Dr. Hevern, you said you have testified before.

What was the context in which you testified before?

A. In a number of malpractice cases.

Q. Okay. And did you testify as an expert witness or as a party to the litigation or both?

A. Party to -- excuse me, party to the litigation.

Q. Okay. Have you ever been engaged as an expert in litigation before?
A. No.
Q. Okay. Have you ever advertised your services as an expert?
A. No.
Q. Are there any cases where even if you didn't testify as an expert you evaluated the case materials or prepared a report?
A. On two occasions.
Q. Okay. And what were those occasions?
A. One was reviewing a case in Boston here for a lawyer who was defending a physician who had died, concerning a man who had overdosed on methadone.
Q. Okay.
A. And the second case was reviewing a case for a man from Vermont who had -- was an alcoholic, and there was a change in his will following his discharge from the hospital.
Q. Okay. With the case that was here in Boston, when was that?

A. I don't remember explicitly, but I would say in the last eight years.
Q. Okay. Did you prepare a written report for that?
A. No.
Q. Okay. And how about the second case, the man from Vermont, when did that occur?
A. Probably in the early 2000s.
Q. Okay. And are those the only two instances in which you have provided expert services to litigation prior to your engagement with this case?
A. Correct.
Q. Okay. And in the cases in which you were a party to litigation, how many cases are we talking about?
A. Seven.
Q. Seven.
Okay. When was the earliest of those?
A. In the 1980s.
Q. 1980s.
Okay. And when was the most recent?

A. Probably in the late '90s or early 2000s.

Q. How did these seven cases resolve?

A. Two of them I was removed from. I don't know what the word would be used, legal, but I never went to court, and they dropped my name from the legal suit, so whatever that is.

Two of them went to court and it was a verdict on my behalf, positive.

And three of them were settled out of court.

Q. Were all of these in the same venue, in the same geographic location?

A. They were all in New Hampshire.

Q. Of the three that settled, when did those take place?

A. In the late '90s maybe, early 2000s. I don't specifically recall.

Q. And all of these were med mal cases?

A. Correct.

Q. Okay. What was the nature of the allegations -- I know we're talking about

seven different cases here, but were they all relating to the same type of treatment or a variety of treatment?

A. Almost all different varieties.

Q. Okay. Could you describe them for me?

A. Which ones? I don't --

Q. Start from the beginning.

A. The two that were dismissed was -- I was on -- was a -- an inmate in a jail that I was on call for and there was an accusation that I delayed treatment. And after deposition, that was found -- I was dismissed.

The second one was a woman who had a septic emboli and died of a intracranial bleed on a weekend that I was not on call, and that was dismissed.

The two cases that I won was -- one was a case in which the -- a man who had been hospitalized at the Riverway Center for Recovery for alcoholism signed himself out against medical advice on a weekend that I was not on call and within a number of hours hung himself.

Let's see. The next case was a woman who presented with premature labor. I was not her treating obstetrician. I transferred her to an obstetrician who then transferred her down to Boston and the baby was born, and there was an accusation that I didn't effectively manage that. And so the child was born with some delays but did fine, you know, is ultimately alive and well now.

The cases that were -- that were settled out of court was -- again, I was on call for an obstetrical case. They -- the accusation was is that there was a delay in doing a cesarean section for a baby in distress. I was named in the suit, I was never deposed, and it was settled out of court.

The next case was I was on call for a -- you know, one of the people that I was on call for. A woman called on a call and had some chest pain that had previously been worked up. I recommended that she go to the emergency room. She delayed in going for 24 hours, and she developed a compression of her thoracic vertebrae and became paraplegic.

So that -- that -- I was deposed on that, and that settled out of court.

And the last and final case was a case of mine in which a man who had rectal bleeding, who I recommended a colonoscopy, he declined. He had a sigmoidoscopy, which was negative, and subsequently died of colon cancer.

Q. Thank you for going through that.

So just reviewing what you just explained of these cases which you were a party to and then the two that you consulted on as an expert, it sounds like only one of them was related to opioids; is that correct? The methadone overdose case?

A. Correct.

Q. And what was the -- and you testified that you didn't provide a written report; you just evaluated the case?

A. Correct.

Q. Okay. Other than these litigation contexts, have you ever testified in a different capacity, for example, before Congress or before a federal agency?

A. No.
Q. So how did your participation in this case come about?
A. I received a phone call from Dechert.
Q. Had you ever worked with Dechert previously?
A. No.
Q. Were you surprised to get that call?
MR. BLANK: Objection.
THE WITNESS: Yes.
QUESTIONS BY MS. GAFFNEY:
Q. And why were you surprised?
MR. BLANK: Objection.
THE WITNESS: I didn't know who Dechert was. I didn't have any idea of what was -- why my name might have been selected.
QUESTIONS BY MS. GAFFNEY:
Q. On that initial call with Dechert, did the person you spoke with tell you whom he or she represented?
A. Yes.
Q. I'm correct in assuming that

they told you they represented Purdue?

A. Correct.

Q. Any other defendants in this litigation?

MR. BLANK: I'm sorry, objection.

MS. GAFFNEY: I can clarify that question.

QUESTIONS BY MS. GAFFNEY:

Q. At the time they told you who they represented on that initial phone call, was it Purdue only or were any other defendants mentioned?

A. I think they only said Purdue.

Q. Okay. And can you describe for me in your own words what this case is about?

A. The case from my observation is about two counties in maybe the state of Ohio, I'm not exactly sure, who is claiming that the current opioid crisis is the result of aggressive marketing of and an increase in the availability of prescription opioids.

Q. Okay. And why did you decide to testify in this case?

A. Because I don't think that's

correct.

Q. What was your understanding of what your assignment as an expert would be when you were first contacted about this case?

A. Was to render my opinion with regards to my -- I'm being distracted a moment. Hold on for just one second. I'm being distracted by people.

Q. I understand.

A. I apologize.

I'll go back on. I apologize for that, but it just pulled my ears away.

So ask the question again. I, again, apologize, if you wouldn't mind.

Q. No problem at all.

The question is, what was your understanding of what your assignment as an expert would be when you were first contacted about this case?

A. Okay. What I saw my job to be was to provide the -- Dechert with my opinion with regards to my opinion as to how I viewed the current, you know, opioid crisis, what was -- what was my opinion about that.

Q. Okay. And when you say "the current opioid crisis," what does that mean to you?

A. Well, it's a complex issue, and it's a complex problem.

Q. So when you say "the current opioid crisis," what's the time frame that you're thinking of?

A. It begins -- well, it's variable. It begins in the '90s and goes through to current day.

Q. When was it that you were first contacted about serving as an expert in this case?

A. Mid-March of this year.

Q. Do you have a signed retainer agreement?

A. I do.

Q. And is it between you and Dechert or between you and Purdue?

A. I think it's between Dechert and Purdue and me is what my understanding is.

Q. Do you remember when you signed this agreement?

A. I don't know if it was April 1st or April 8th. I can't -- it was probably April 8th. Okay.

Q. Are there any restrictions in your assignment, such as opinions you were asked not to offer or parties you could not offer opinions about?

MR. BLANK: Objection.

THE WITNESS: Oh, I was never -- I was simply asked to render my opinion obviously.

QUESTIONS BY MS. GAFFNEY:

Q. And are you rendering your opinion on behalf of Purdue only or any of the other defendants in this case?

A. I've been retained by Dechert, and so I -- they were the ones that asked me to produce the work, so I don't know how it's going to be used other than what Dechert and Purdue are choosing to use it. And I don't know that goes -- how that works.

Q. But you did not sign a retainer agreement with any other defendant in this litigation?

A. Correct.

Q. Have you had any in-person or telephone meetings in which representatives of other defendants in this litigation were present?

A. No, not that I know of, other than this, what's happening today.

Q. Your compensation rate in this matter is $500 per hour; is that correct?

A. Correct.

Q. And is that the same rate for deposition, for trial, for travel, or does it vary?

A. No, it's -- that's the -- that's the rate that it would be charged.

Q. How did you determine that rate?

A. It's a compilation of 99213s times 4.

Q. What does that mean?

A. 99213s is the billing -- billing for the -- for a visit to a doctor's office, and the compensation rate is about $125 for a 99213, times it by 4 is $500.

Q. Understood. Thank you.

A. You're welcome.

I'm.

Sorry, it's...

Q. Do you have -- do you know roughly how much time you've spent working on the case so far?

A. In total, about 60 hours or so.

Q. Approximately how much time of that was spent preparing your report?

A. Approximately 30.

Q. And how much time preparing for your deposition today?

A. Probably, let's see, 16.

Q. What did you do to prepare for your deposition today?

A. I spoke with counsel.

Q. In-person meetings or telephone conferences or both?

A. In-person meetings.

Q. How many in-person meetings?

A. Three.

Q. When did those take place?

A. Last Saturday, I can't recall the date. Monday and Wednesday of this week.

So I'd revise my statement. It was about ten hours of preparation now that

I've added it up in my head.

Q. Okay. Thank you.

And that leaves approximately 20 hours.

How did you spend those other 20 hours?

A. Reviewing -- I reviewed some of the expert witness information and reviewed my own -- my own expert -- expert presentation, reviewed it a number of times; reviewed my CV to try to get it into my head a little bit more clearly; did some, you know, additional reading on the matter.

So that would be what I did.

Q. Thank you.

And when you say "additional reading," what sort of materials were you reading?

A. I read -- you know, I reread some of the articles that I had noted. I wound up looking at some of the information that was presented in some of the expert witness testimony, read some reports from CDC and NIDA and -- is what I did.

Q. With respect to the articles

that you reread, are there any that stand out?

A. None in particular.

Q. And how about for the expert witness testimony that you reviewed, were there any expert reports or deposition transcripts that you focused on in particular?

A. I looked at Lembke and Schumacher, Schumacher.

(Hevern Exhibit 2 marked for identification.)

QUESTIONS BY MS. GAFFNEY:

Q. I'll mark as Exhibit 2 the invoices that we received.

All right. Your counsel provided us with these copies of your invoices.

Did you prepare these invoices?

A. I did.

Q. Okay. And are there any invoices that you have not yet submitted for the work that you've done thus far?

A. Yes.

Q. Approximately how many hours'

work are on the invoice that has not yet been submitted?

A. I'm going to say maybe the 30 -- 30 hours.

Q. Okay. And the 30 hours would be -- when did that work take place?

A. In the last two weeks.

Q. In the last two weeks.

Who pays your invoices?

A. Excuse me?

Q. Who pays your invoices?

For example, does the payment come from Dechert? From Purdue?

A. I haven't received any payment yet so I don't know.

Q. Fair enough.

A. Just --

Q. To be determined.

Has anyone assisted you with your work on this case?

A. No.

Q. Other than meeting with your counsel, did you speak with anyone else about your deposition today?

A. Just my family. And my -- and

work.

Q. And what was the nature of your discussions with your family and with work about the deposition?

A. They were wondering what I was doing and where I was going and what -- it was simply to inform them of where I was going to be and whether or not I was going to be available or not.

(Hevern Exhibit 3 marked for identification.)

QUESTIONS BY MS. GAFFNEY:

Q. Okay. I'll mark your report and its exhibits as Exhibit 3 to the deposition.

I would first like to ask you about your CV.

You submitted your CV as Exhibit A to your report; is that correct?

A. Correct.

Q. And did you prepare this, your CV?

A. Yes.

Q. Exhibit A includes what appear to be two separately formatted CVs, with the

second CV listing honors and awards; is that right?

A. Correct.

Q. And so just for the sake of clarity, when I refer to your CV, it's to both of them together.

A. Yes.

Q. All right. Do you have any other versions of your CV that you use for purposes other than litigation?

A. This is the only one I have.

Q. And you said you reviewed your CV before it was submitted; is that correct?

A. Correct.

Q. And so is it your testimony that your CV is accurate and up to date?

A. It is.

Q. So going through your educational background, you obtained your medical degree from SUNY Stony Brook in 1976?

A. Correct.

Q. Do you recall anything about your medical school training related to use of opioids?

A. I don't recall.

Q. When you graduated from medical school, what were your views on prescribing opioids?

MR. BLANK: Objection.

You can answer.

THE WITNESS: I saw them as a necessary part of the management of acute medical needs that are associated with pain.

QUESTIONS BY MS. GAFFNEY:

Q. Could you give me some examples of what those acute medical needs associated with pain entail?

MR. BLANK: As of 1976?

MS. GAFFNEY: Yes.

THE WITNESS: They would have been postoperative treatments and trauma.

QUESTIONS BY MS. GAFFNEY:

Q. Has your view on prescribing opioids changed since that time?

A. No.

Q. Your CV states that you completed a family practice residency in Ontario in 1978; is that right?

A. Yes.
Q. Do you remember if you prescribed opioids to your patients in your family practice residency then?
A. I would assume I did, but I can't answer that with definitiveness.
Q. Going on the assumption that you did, what sort of conditions would you have prescribed opioids for in that family practice?
A. My recollection would have been in an inpatient setting. I don't believe I was asked to manage patients in an outpatient setting with opioids, other than maybe some, you know, again, acute trauma, but it's going back a fair amount of time.
Q. Understood.
So this was an inpatient setting that was at St. Joseph's Hospital?
A. Correct.
Q. Could you tell me a little bit about what a family practice residency is in an inpatient setting?
When I think of family practice, I think of outpatient.

A. Correct.

So let me speak then toward the University of Western Ontario.

Q. Uh-huh.

A. It divided itself between six months' rotation in an inpatient setting and six months' rotation in an outpatient setting. And so in an inpatient setting you were -- in your first year you were treated as an intern and you did whatever service that you were on, a medical service, obstetrical service, pediatric service, et cetera.

And then in the second year you were treated as a second-year resident, just as if you were a second year resident in orthopedics or surgery or OB/GYN, et cetera, and you were then in the position to supervise other interns and medical students in that setting.

So that's an inpatient setting process.

In an outpatient process, it was in a fixed location in which patients in that location remained a cadre of patients

that would be passed on from resident to the next resident to the next resident. So that's -- and there was supervising family physicians that kind of oversaw that process.

And that would be a general overview.

Q. Thank you.

And do you remember how you would have used opioids in that time?

MR. BLANK: Objection.

QUESTIONS BY MS. GAFFNEY:

Q. For your patients?

MR. BLANK: Objection.

THE WITNESS: Again, my -- I don't have a recollection of explicit interactions. My assumption would be that I used them for acute trauma, but I don't know what -- I don't have -- I can't recall explicit events.

QUESTIONS BY MS. GAFFNEY:

Q. That's fine.

So you've mentioned a couple times using opioids for acute trauma, pain related to acute trauma.

Is there a point in time when

you began prescribing opioids for chronic pain?

A. When I established my practice in New Hampshire.

Q. And when was that?

A. When I established my practice is in 1979.

Q. 1979.

And why was that a point in time when you began prescribing opioids for chronic pain?

A. Surgeons were asking me to essentially consult on patients that were having -- they were having difficulties managing their pain.

Q. When you say "surgeons" were asking you to consult, is that in the context of postoperative pain?

A. Correct.

Q. And how does postoperative pain relate to chronic pain?

A. In the instances that I was being consulted, these were major trauma patients in which these patients were -- and the first person I do recall was a woman at

the age of 16 or 17 who had at that time already undergone conservatively 12 different abdominal surgeries in her life. And so she had transitioned from short-term postoperative care to really long-term because she was on opioids for all of these acute events.

Q. And do you remember with respect to that consultation what the recommendation or care you provided was?

A. The general gist of what I did for her and for many people was being able to transition them from IV administration of medications to oral medications so that they could be discharged from the hospital.

Q. And what would be the oral medications you would transition this patient and other patients like her to?

A. At the time, probably transitioning them to oxycodone and Vicodin, I would imagine, or hydrocodone.

Q. Okay. So oxycodone at that time, would that have been a combination product or --

A. It would have been Percocet,

which is oxycodone and Tylenol, and hydrocodone and Tylenol is Vicodin.

Q. How did you achieve that transition?

MR. BLANK: Objection.

QUESTIONS BY MS. GAFFNEY:

Q. And let me clarify. When you said "IV administration of medications," are we also talking about opioid pain relievers IV administration or something else?

A. Well, variable, but they were often either IV Dilaudid drips or they were morphine drips or they were Demerol IM.

Q. So generally speaking, how would you transition patients from IV Dilaudid or morphine or Demerol IM to Percocet or Vicodin?

A. The mechanism that I used was a slow titration off of the IV medications, and that takes -- that took oftentimes days and then transitioning into oral medications.

Q. So still talking about that time, which would be the 1980s and early 1990s, are there other chronic pain conditions other than these examples of

postsurgical pain that has become long-term pain?

Are there other chronic pain conditions for which you prescribed opioids in that time frame?

A. I would have for failed surgical backs.

Q. What does that mean, "a failed surgical back"?

A. Patients who had surgery for herniated discs or for other kinds of back trauma in which the symptoms persisted and the -- that would be it. Yeah, symptoms continued after the surgery.

Q. Generally speaking, what type of opioid regimen would you prescribe for someone with this situation?

MR. BLANK: Objection.

THE WITNESS: Challenging to go back that long, but my presumption would have been that I would have been using some combination of methadone and short-acting opioids in addition to a number of other medications.

QUESTIONS BY MS. GAFFNEY:

Q. And what would those other medications be, if you could give a couple examples?

A. They would fall into categories of antidepressants, antiseizure medications, muscle relaxants.

Q. Okay. A variety?

A. Yeah, a variety.

Q. Since that time, have your prescribing practices with respect to opioids changed?

A. They have evolved.

Q. Okay. And how have they evolved?

A. There have been new products on the market that I've been able to use, and I've evolved my practice over the last 40 years to accommodate those new products.

Q. Could you describe that in a little more detail?

MR. BLANK: Objection.

THE WITNESS: Well, the -- I have utilized long-acting opioids that were not available, when methadone was

the only long-acting opioid available. So I've used a combination of methadone, fentanyl patches, morphine sulfate control release. Oxy -- oxycodone control release has been my control release.

I've used a variety of short-acting medications as well.

I have utilized 20 or 30 alternative medications, you know, in that period of time that fall into those three general categories that I mentioned above.

QUESTIONS BY MS. GAFFNEY:

Q. So fair to say then what you're describing, much of the evolution in your prescribing practices has been based on the medications that are available?

A. Correct.

Q. And have your prescribing practices using these varieties of opioid medications changed with respect to the conditions which you treat with these drugs?

A. You lost me on that question. I'm sorry.

Q. Trying to be precise, but I realize that was a long question.

Let me go back --

A. Yes, please.

Q. -- because you've described a few instances -- you described postsurgical pain that has become persistent, long-term pain?

A. Yes.

Q. And you've described failed surgical backs situation.

Are there other conditions for which you have used these other opioid formulations?

A. Other conditions would include people who've had chronic, nonsurgically curable conditions such as neuropathies due to chemotherapy, neuropathies due to diabetes, central pain syndrome such as fibromyalgia or post-stroke issues, complex regional pain disorder. You know, a variety of different people who've had rheumatoid arthritis, lupus, most recently the development of EDS, which is Ehlers-Danlos syndrome.

You name the disease, I've looked at it and I've tried to manage the pain that's been associated with those things.

Q. Are there any conditions which in your experience you've found opioids to be not effective?

A. I've been able to use a low-dose naltrexone in some of my patients with great -- and so that's an antagonist, an opioid antagonist. That has become available or at least reported over the last number of years, and it seems to be effective in the management of people who have nerve-related -- long-term nerve-related pain.

Q. Okay. And again, generally speaking, when you do use opioids to treat the chronic pain conditions that you've just described in your patients, what is the average dose range that you prescribe for your patients?

MR. BLANK: Objection.

THE WITNESS: There actually is no average dose range.

QUESTIONS BY MS. GAFFNEY:

Q. Okay. For a patient who has never been on opioids before, what would be the dose range you would start with?

MR. BLANK: Objection.

THE WITNESS: Actually, if -- in the consultative work that I do, if they've not been on opioids, I use all sorts of alternative choices. And if they've already been on those alternative choices, I will then use an opioid.

If I start out with an opioid, I'll give you -- if I start out with, for instance, methadone, I start out about 5 milligrams a day.

QUESTIONS BY MS. GAFFNEY:

Q. Okay. And you said that for patients who have not been on opioids you use all sorts of alternative choices.

Is it fair to say that you do not view opioids as a first-line therapy then?

A. Correct.

Q. What sort of alternatives do

you start with instead of opioids?

A. Well, many of the ones that category -- I can give you names of drugs. Okay.

Q. What categories of --

A. Well, the categories are the things that I mentioned: The antidepressants, you know, antiseizure medicines, muscle relaxants, nonsteroidal anti-inflammatories.

And some of these unique medications -- interestingly enough, some people respond to anti-Parkinson's medications. Some respond to, believe it or not, antibiotics.

So I see such a wide range of people, and my choices are dependent upon what they're presenting me with, I must say.

Q. You mentioned as an example when you might start a patient on opioid therapy using 5 milligrams of methadone, are there -- do you tend to go to methadone first if you're trying opioid therapy, or are there other opioids you also utilize?

A. I generally utilize -- in

initiating medications, I'll generally utilize a low-dose -- opioids that are -- okay. I'll take -- separating out acute pain, I will use a mixed-fixed combination.

Okay. In people that are chronic, I will use -- I'll try to use a, quote, pure, you know, medication.

The reason being is the mixed-fixed combination, Tylenol does induce end organ damage, where the others do not create end organ damage.

Q. And when you use the pure medications, which compounds -- or which molecules do you tend to use?

A. I use oxycodone, morphine sulfate, and I use tramadol, which is a variation of the theme of a straight opioid. And I use Nucynta, which is also a variation in the theme of opioids.

Q. And when you use oxycodone, for example, what's the general dose range that you use?

MR. BLANK: Objection.

THE WITNESS: Generally we start out with 5 milligrams two to

three times a day and then you adjust accordingly.

QUESTIONS BY MS. GAFFNEY:

Q. And the 5 milligrams two to three times a day, that would be the short-acting oxycodone; is that correct?

A. Correct. Right.

Q. Are there situations where you would use the long-acting over the short-acting?

A. When they have -- when patients have failed at short-acting controlled, we'll go to long-acting controlled -- I mean, long -- excuse me, medicines that have long-acting half-lives or they have a -- they're a control release is what I'm trying to say. I apologize.

Q. So after patients have failed at short-acting, then you might try the controlled release?

A. Correct.

Q. And can you explain that to me a little bit?

If the patient -- what does that mean if the patient has failed at the

short-acting formulation?

A. Their symptoms persist. They haven't improved functional activity. They have continued to be unable to participate in either activities of daily living or social interactions or general social settings is what I consider a failure of short-acting medications.

Q. And in that context, why might the controlled release help?

A. Control-release medicines in general do provide a consistent level of opioids in the system over a period of time, and so you're not going through peaks and troughs of medications that are short-acting.

Q. You've described a couple times fairly -- using fairly low doses of opioids with your patients at 5 milligrams of methadone and 5 milligrams of short-acting oxycodone.

Is there in your practice an upper range that you would go to in terms of the dosage strength?

MR. BLANK: Objection.

THE WITNESS: I have -- in my

current position, I am managing many legacy patients who have been on higher doses of opiates that I did not initiate. And so I've taken care of people who have been on probably 4 to 500 milligrams of oxycodone, 400 milligrams of methadone.

QUESTIONS BY MS. GAFFNEY:

Q. That's a daily amount?

A. Yes.

Q. But those are legacy patients for whom you did not initiate the medication, that's correct?

A. Correct.

Q. What about for patients whose opioid treatment started with your care?

MR. BLANK: Objection.

THE WITNESS: And the question again? I apologize.

QUESTIONS BY MS. GAFFNEY:

Q. Sure, that was not very clear.

In your experience is there -- do you perceive an upper bound for the amount of daily dose of opioid that you're comfortable prescribing to your patients?

A. There are some upper limits that I begin to say, if you're having more of this, we need to be looking at alternative choices. And generally when people are getting up to about 200 milligrams of oxycodone or its equivalency in maybe morphine sulfate, I begin to say, you know, more may not be better. We need to begin to look at alternative choices or we need to begin to look at all of these other lists of medicines that I have -- categories of medicines that I have indicated before and begin to go through the 20 or 30 meds that I use within the context of that.

Comparably, I use a whole different approach to the set of circumstance in terms of getting people to be motivated to increase activity levels, and so I do a pretty comprehensive process with these people.

Q. What does that comprehensive process entail?

A. Well, I've got about 10 or 20 handouts that I give. I give them activity levels that are doable and begin to mark

progress based upon that.

Q. What sort of information do the 10 or 20 handouts cover?

A. There are two fanatic groups. The first is to identify that the management of chronic pain syndromes is divided into behavioral changes that are spiritual components, medication management, trust between the physician and the doctor {sic}, physical activity. It requires -- it requires the use of adaptive devices. It requires management of expectations.

We discuss spirituality, and we discuss choices of them developing a plan of activity and action that they then become adherent to versus me prescribing something.

Q. That makes sense.

What are the adaptive devices you mentioned?

A. I have prescribed shoes, socks, belts, neck braces, hand braces, underwear, canes, wheelchairs, pillows, beds.

Q. Okay.

A. Those are all adaptive devices that exist in this world.

Q. Got it.

Why, in your experience, is around 200 milligrams a day the point where you want to start looking at alternatives?

A. Certainly the challenge that all patients face currently are the guidelines that have been created by CDC and by insurance companies. And to achieve a prior authorization for more medications greater than that is challenging for me and for the patient. That's number one. There's a barrier that gets created.

Two, there is certainly evidence that suggests that increasing doses puts people at some increasing risk for potential overdoses.

And finally, the concept of doing more of the same thing doesn't necessarily give you a better outcome.

Q. The first factor you mentioned, the CDC guidelines, policies from insurance companies, those have been more recent factors; is that correct?

I presume you're speaking of the 2016 CDC guideline?

A. Yes, there have been -- there have been both CDC guidelines, there actually have been Medicare guidelines, there have been different insurance company guidelines, and they all kind of been -- been placed in public arenas so that people can review them.

And these were discussed in the American Society of Addiction Medicine meetings as early as the 2000s.

Q. Okay. So in terms of a factor that you consider in your practice, would these external guidelines have been something that you were considering in the 2000s when -- in terms of the dosage that you prescribe for your patients?

A. I've always considered, you know, that -- I mean, even though those guidelines have become more published, I've always considered whether or not more is going to be better, you know. That's been a historical component.

Q. And is this general benchmark of approximately 200 milligrams something that has kind of always been the point where you would look at alternatives in your

practice, or has that changed over time?

A. It has not changed over time.

And I'm trying to also say that that number is not the number that then creates my desire to then introduce all of these other medications. It's not like, oh, you hit 200, now we have to consider this.

We're doing that on the spectrum of patient care is what I'm trying to say here.

Q. That makes sense.

And knowing that we're talking about many years of your medical practice here, I'm just wondering about changes over time. And since the first factor you mentioned, the guidelines and insurance policies, I wasn't sure if that had been a more recent factor that you consider or if that has been your consistent practice for decades.

A. It has been. That's what I'm trying to indicate by that last statement.

Q. And again, speaking generally, how long would you say that you have kept your patients on chronic opioid therapy?

MR. BLANK: Objection.

THE WITNESS: I have cared for people who have been on chronic opioid therapy for 20, 30 years.

QUESTIONS BY MS. GAFFNEY:

Q. And those patients who have been on chronic opioid therapy for decades like that, what -- again, generally speaking, what dose of opioid therapy are they on for that length of time?

A. Actually very variable. It's not like -- from fairly low doses of one or two Vicodin a day -- well, actually two Vicodin a day, this one fellow, up to this one man that I am caring for who has been on -- who was a legacy patient. He currently is on about 200 or 230 milligrams of morphine per day. I mean, methadone per day. I apologize.

Q. And with patients who are on opioid therapy for that length of time, are there things that you do to avoid the issue of dose escalation and tolerance?

A. Well, what occurs is that they -- once they achieve these doses, they

remain very functional at that. They don't -- that's what I'm saying to you, these -- if you're on them for decades, they've achieved a stable dose.

MR. BLANK: Counsel, if you reach a good point, we've been going for a little bit over an hour, so a break would be appropriate.

MS. GAFFNEY: Yeah, let's take a break.

VIDEOGRAPHER: We're going off the record at 10:12 a.m., and be careful of your microphone, Doctor.

THE WITNESS: Oh, great. Thank you.

(Off the record at 10:12 a.m.)

VIDEOGRAPHER: We're back on the record at 10:36 a.m.

QUESTIONS BY MS. GAFFNEY:

Q. Welcome back, Dr. Hevern.

A. Thank you.

Q. Earlier you were testifying about your prescribing practices with respect to opioids and that your prescribing practices have been fairly consistent over

time while incorporating newly available formulations.

Is that a fair summary?

A. Yes.

Q. So taking a step back and speaking about the medical community generally, in your view, have the prescribing practices of the overall medical community with respect to opioids changed in the time that you've been practicing, medicine?

MR. BLANK: Objection.

THE WITNESS: I don't -- I can't tell you about that explicitly because I don't know.

QUESTIONS BY MS. GAFFNEY:

Q. In your observation practicing medicine for decades, is it your view that prescribing practices have remained consistent with respect to opioids?

A. What do you -- I'm not sure what you're trying to ask. I apologize.

Go ahead.

Q. I'm trying to think about how to phrase this a different way.

So looking at the -- and I'll

narrow it from the medical community to primary care physicians, family practice doctors like yourself.

Is it your view that most family practice doctors prescribe opioids in the same way that you do?

MR. BLANK: Objection.

THE WITNESS: It's very variable from doctor to doctor.

QUESTIONS BY MS. GAFFNEY:

Q. And what are some of the variations that you see?

A. The variations are doctors not prescribing any to doctors that are comfortable prescribing some or -- some -- some more particular -- a particular opioid for their patients.

Q. You mentioned earlier that you cared for some legacy patients who are on higher doses than what you would generally prescribe, 4 to 500 milligrams of an opioid a day; is that right?

A. Correct.

Q. And in your view, would you consider that overprescribing, when these

patients come to you on that high of a dose?
MR. BLANK: Objection.
THE WITNESS: No.
QUESTIONS BY MS. GAFFNEY:
Q. And why not?
A. The patients who present with those doses are still functionally -- excuse me, are still doing -- functionally doing okay at those doses. So they both are tolerating medications and are doing reasonably well on them.
Q. You testified when we first began talking that your understanding of the litigation is that the plaintiffs in this case are claiming that the current opioid crisis is the result of aggressive marketing of and an increase in the availability of prescription opioids.
And then you testified that you decided to participate in this case as an expert because you don't think that is correct.
Do you recall that testimony?
A. Yes.
Q. So in your view if the current

opioid crisis -- in your view, if it's not correct that the opioid crisis is the result of aggressive marketing and an increase in availability of prescription opioids, what do you see as having led to the current opioid crisis?

MR. BLANK: Objection.

THE WITNESS: Well, that's what's in my report, and so it's in my report.

QUESTIONS BY MS. GAFFNEY:

Q. Can you answer the question just summarizing in your own words what your view is on this?

MR. BLANK: Objection.

THE WITNESS: It's a complex issue. Addiction has existed for decades, if not centuries, in the United States, that it's an outcome of a variety of problems that are outlined in my -- in my -- in my expert test -- expert report.

QUESTIONS BY MS. GAFFNEY:

Q. You testified earlier that in your view when you use the phrase "current

opioid crisis," you're referring to something that began in the 1990s and continues to present day; is that correct?

A. Correct.

Q. So given the view that you just explained about addiction being something that has existed for decades, if not centuries, what led to the beginning of the current opioid crisis in the 1990s?

MR. BLANK: Objection.

THE WITNESS: Cocaine was the largest challenge in the '80s and '90s. Heroin came back into the -- not came back in, but was again fairly available.

Again, my report -- I mean, I can repeat the issues in my report, and I will, but the need to address underlying chronic pain conditions as a result of medical problems, the closing of facilities, the challenges of mental health, reduction in a workforce that was providing, you know, valuable resources, emergence of a lot of psychological trauma.

So there's many, many factors that are -- and that's what I tried to give in my report.

QUESTIONS BY MS. GAFFNEY:

Q. And how does the need to address underlying chronic pain conditions as a result of medical problems factor into the development of the opioid crisis?

MR. BLANK: Objection.

THE WITNESS: How does the what?

QUESTIONS BY MS. GAFFNEY:

Q. The first factor you listed was the need to address underlying chronic pain conditions as a result of medical problems.

How does that factor into the current opioid crisis?

MR. BLANK: Objection.

THE WITNESS: Well, there was a problem identified in the late '90s and early 2000s that physicians were inadequately managing chronic pain.

QUESTIONS BY MS. GAFFNEY:

Q. How does that relate to an opioid crisis?

MR. BLANK: Objection.

THE WITNESS: The pressure was placed upon the hospitals and communities and physicians to address this issue, and one of those medications or a group of medications that could address that issue were opioids.

QUESTIONS BY MS. GAFFNEY:

Q. So if this group of medications is being used to address a need that had been identified of inadequately managed chronic pain, how does that relate to development of an opioid crisis?

MR. BLANK: Objection.

THE WITNESS: It's a factor that contributes to medicines that were available -- excuse me, that were available to be diverted.

QUESTIONS BY MS. GAFFNEY:

Q. So am I correct in understanding what you're saying is that the increased availability of prescription opioids was a factor in the development of the opioid crisis?

MR. BLANK: Objection.

THE WITNESS: What I'm saying is that the appropriate prescription of opioids to patients who needed them did not contribute to the problem, but there was diversion of medications that did occur.

QUESTIONS BY MS. GAFFNEY:

Q. And what is your understanding of the diversion of medications that did occur?

A. Medicines were taken or stolen from people who were getting prescriptive prescriptions, legitimate prescriptions, and that was a source of diversion.

Q. Is it your opinion that all of the opioids that were prescribed for chronic pain were, as you say, legitimate prescriptions?

MR. BLANK: Objection.

THE WITNESS: As far as I would determine, yes.

QUESTIONS BY MS. GAFFNEY:

Q. And what's your basis for saying that?

A. My own personal experience and the experience of people that I met in different pain conferences that I went to and different -- that were supported by the American Pain Society, that there was a legitimate use for opioids.

Q. So just to understand, it's based on your own personal experience but also your knowledge of the prescribing practices of other physicians?

A. I don't have personal knowledge of prescribing practices, but, again, it's a -- it is knowledge arrived by conversation with and attendance at educational lectures that were geared toward informing physicians who were managing chronic pain.

Q. When you refer to educational lectures, you mentioned a moment ago the American Pain Society.

Are you referring to the same thing? Are these educational lectures supported by the American Pain Society?

A. There's -- yes.

Q. And with this knowledge arrived by a conversation with other physicians and

attendants at lectures such as these, did you see a change in prescribing practices over time with respect to opioids?

A. There was an increase in the prescriptive -- in prescribing opioids during the 20 years that I attended these lectures, yeah.

Q. Going back to what you said a moment ago about diversion and the medicines being taken or stolen from people who were getting legitimate prescriptions as a source of diversion, what's the basis for your saying that?

A. Police reports.

Q. Your review of police reports; is that what you mean?

A. Presentations on TV and radio.

Q. In your practice, have any of your patients ever experienced having their prescriptions taken or stolen from them?

A. Yes.

Q. Are you familiar with the term "pill mill"?

A. Yes.

Q. And what is your understanding

of what that refers to?

A. The, I would say, rogue physicians and rogue pharmacists that were writing prescriptions for illegitimate reasons in large quantities for cash in certain locations of the country.

Q. And you mentioned certain locations of the country.

What are you referring to?

A. I understand something existed in Florida, in Appalachia and a couple of other locations, but I haven't taken note of all the locations that have been published on TV.

Q. And in your experience practicing medicine in New Hampshire, were you aware of any pill mills in that geographic area?

A. None that I know of.

Q. In your view, have these pill mills or, as you say, rogue physicians and rogue pharmacists contributed to the development of the opioid crisis?

MR. BLANK: Objection.

THE WITNESS: I can only assume

that they did.

QUESTIONS BY MS. GAFFNEY:

Q. You state in your report that you've been involved in the care of scores of patients who wanted or needed to be tapered from their opioid-based medications.

I can give you a moment.

A. Where are we referring to?

Q. Page 8. It's the second full paragraph on page 8.

A. Yes.

Q. So when you say "wanted or needed to be tapered," what do you mean by that?

A. In some instances they had come to the end of their acute need of medications, and they were having difficulties stopping their medication.

In other instances they had achieved an improved functional capacity and were looking for the lowest effective dose of medication.

Q. And you explain that by creating a plan, monitoring the patient and reducing the patient at this low rate

successful tapers have been achieved.

What does this plan look like, generally speaking?

MR. BLANK: Objection.

THE WITNESS: It's different for every individual, and it includes medication adjustment downward and providing the alternative meds that I had stated earlier.

QUESTIONS BY MS. GAFFNEY:

Q. You testified a moment ago that there has been an increase in prescribing opioids during the 20 years that you were attending the lectures that you described earlier.

Why do you think there was an increase?

MR. BLANK: Objection.

THE WITNESS: To meet the unmet need of patients.

QUESTIONS BY MS. GAFFNEY:

Q. And is it your view that with the increase in opioid prescribing, that that unmet need has now been met?

A. It has been improved.

Q. In the instances with your patients, if you're starting an opioid naïve patient on opioid therapy, what do you tell the patient about opioids?

A. That there are side effects and there are challenges with its -- with their use.

Q. What are the side effects you tell your patients about?

A. Things like constipation, itching, potentially cognitive changes.

Q. Are there any other side effects you tell your patients about with opioid therapy?

A. Those are the side effects that I would highlight.

Q. Okay. How about the challenges?

A. Challenges are they can have emotional changes, either positive or negative, and mostly I dwell on the negative. And there is a -- there are risks for opioid-induced overdose, oftentimes unintentional, and they need to safely manage their medications.

Q. How do you recommend that patients address the challenge of the risk of opioid-induced overdose?
A. Not to take more than they are prescribed. I check the PDMP to make sure there's no other prescribers and ask them to inform me if there are changes that are occurring that are -- that they're uncomfortable with.
Q. What sort of changes?
A. Whatever they choose to call me up and tell me about.
Q. Do you ever co-prescribe Naloxone with opioid treatment?
A. Yes.
Q. When do you do that?
A. In the initiation of the prescriptive events.
Q. For every patient or for certain patients?
A. It's now become standard for every patient.
Q. When did that change come about, that standard?
A. Recently because -- recently,

really.

Q. Is that something in your practice you started doing five years ago? A year ago? Just approximately?

A. Within the last year.

Q. So as we've discussed, when you said "current opioid crisis," you said it began in the 1990s.

When did you become aware of it?

A. Well, addiction has been a part of what I've been doing now since 1979, so it's been ever present in my life in terms of my clinical -- you know, my clinical set of circumstances. So it wasn't like it was an ah-ha moment.

Q. And understanding that addiction has been part of your practice as long as you've practiced, you testified that the current opioid crisis began in the 1990s.

So would you say that you became aware of it as soon as it began at that time?

A. It -- the pattern of use of heroin in the mid-'90s became much more of

a -- of something I was clinically seeing in the Riverway Center for Recovery, and that was new in that -- in the city and in that location.

Q. And was there a point in time when you were also seeing abuse of prescription opioids in your clinical practice?

A. Well, by 1999 the Riverway had closed down, and so I was not performing addiction services at that time, and so -- so, no.

Q. In your family practice, is that something that you have ever seen, patients abusing prescription opioids?

A. Yes, there have been some individuals in the practice.

Q. Looking at Exhibit A, your CV, under the heading Licenses and Certificates.

A. Yes.

Q. One of the listings there is 2001, American Pain Society.

And do you have a license or a certificate from the American Pain Society?

A. That's a society that I belong

to, but I'm not licensed by them.

Q. And you mentioned earlier attending conferences supported by the American Pain Society.

In addition to attending those conferences, how else have you been involved with the American Pain Society?

A. Mostly through conference participation.

Q. How would you describe the American Pain Society?

A. It has been a group of physicians nationally that have been involved with pain management for decades.

Q. And how many conferences sponsored by the American Pain Society would you say you've attended? Was it once a year? Twice a year?

A. Generally once a year since the early -- maybe mid-'90s.

Q. Have you ever held any leadership positions with APS?

A. No.

Q. Would you say that APS has ever taken positions, issues, with respect to

opioids?

A. I don't know.

Q. Your CV also lists participation as a member of the Manchester Cooperative Pain and Opioid Project?

A. Yes.

Q. Can you tell me about this project?

A. It was a short-lived project that was an attempt to gather the Elliot Hospital, this -- Catholic Medical Center, and Hitchcock Medical Center into a collaboration to begin to look at the -- how were we going to provide services within the community.

We had a number of meetings, and the Catholic Medical Center then took leadership in the process, and they have -- the cooperative pain project then became their, kind of like, project. And then all of a sudden Elliot Hospital and the -- and Hitchcock kind of like faded out of that process.

So I have not -- to be honest with you, I was in it from 2016 to 2017, and

I...

Oops, I can't do that. I apologize.

MR. BLANK: The witness has marked the exhibit --

THE WITNESS: I apologize.

MR. BLANK: -- correcting it from -- that entry from 2016 to present to 2017.

Just letting you know.

MS. GAFFNEY: Thank you.

THE WITNESS: Sorry.

QUESTIONS BY MS. GAFFNEY:

Q. Your CV does not include any publications that you've authored.

Have you ever published any articles or editorials?

A. I have not.

Q. Your CV does list a number of lectures and presentations.

Would you say that you have kept detailed records of the presentations you've given?

A. No, I have not, except for the last few that I -- you know, in the last year

or so.

Q. I was impressed that you noted that you spoke at the West High School parents night on September 19, 1990.

A. Yes.

Q. So how do you keep track of details like that?

A. I try to enter the events close to when they have happened, so...

Q. That makes sense.

A. And my nephew was going to school at the time.

Q. For the presentations in the last year or so, do you have materials from any of those presentations?

A. I have -- for the Pain and Addiction and New Approach to Management Strategies, I have that, and I still have the Chronic Pain in America slides.

Q. Okay. Have you provided your counsel with those materials?

A. They didn't ask.

MS. GAFFNEY: Counsel, we would like to request production of those materials.

MR. BLANK: We will take that under advisement.

QUESTIONS BY MS. GAFFNEY:

Q. One of the presentations listed, it's grand rounds at the University of Massachusetts Medical Center in Worcester on December 8, 1999. The title is "Pain Management in the Emergency Room Setting: Treatment Choices That Reduce Abuse Potential."

Do you remember that presentation at all?

A. Vaguely.

Q. What do you mean -- what did you mean by "treatment choices that reduce abuse potential"?

A. Granted, my memory is somewhat selected here, but it was introducing at that time the concept of alternative treatment models to begin to look at frequency of presentations to the emergency room and looking toward -- those would be the things that I would say that I can recall.

Q. Alternative treatment models. Alternative to what?

A. Alternatives to simply providing pain medications for presentations to the emergency room.

Q. And what would be some of those alternative treatment models?

A. Again, looking 20 years -- 20-some-odd years ago, they would have included the uses of nonsteroidal anti-inflammatories. They would have used antidepressants. They would have used at that time short courses of medications of opioids, if you were going to use that.

So those were some of the components of really what I spoke toward.

Q. You also list a presentation on The Fifth Vital Sign: Effective Management of Acute and Chronic Pain given at Lawrence General Hospital in September of 2001.

Do you remember that presentation at all?

A. I remember some of that, that -- I remember some of that.

Q. What does that refer to, the fifth vital sign?

A. The Joint Commission that

accredits hospitals had asked hospitals to include in their assessment a patient's pain, and that became the fourth vital sign -- the fifth vital sign, excuse me, in addition to the four that we normally do.

Q. So how did you end up giving that presentation?

A. I was asked to -- I was asked to provide that presentation as a result of Joe Russell, who was a Purdue rep, who had -- who had created -- who linked me with them, that's all I can tell you, through their CME committee.

Q. When you say "linked you with them," who is "them" that you're referring to?

A. The continuing medical education committee at Lawrence General Hospital.

Q. And Joe Russell, the Purdue rep you mentioned, is he a representative who visited your practice frequently, or how did you know Joe Russell?

A. He would come two to three times a year.

Q. For which years, approximately?
A. I don't recall explicitly.
MS. GAFFNEY: Go off the record?
THE WITNESS: Okay. No, something -- yeah. All of a sudden I felt this move. I apologize.
QUESTIONS BY MS. GAFFNEY:
Q. So the Purdue representative connected you to the CME team at Lawrence Hospital.
Are you aware of whether Purdue sponsored that talk at all?
A. They did.
Q. Did that sponsorship of that talk involve any honoraria for you as the speaker?
A. Yes, it did.
Q. And is that something that you disclosed to the audience when giving that talk?
MR. BLANK: Objection.
THE WITNESS: I probably did, but because -- part of the -- my assumption is yes.

QUESTIONS BY MS. GAFFNEY:

Q. Looking over this list of presentations, are any other of these presentations here sponsored by drug manufacturers?

A. The Recent Advances in Premenstrual Dysphoric Disorder in 2000, you know, was sponsored by Lilly.

And the one in 2001, Antidepressant Therapy, was sponsored by Lilly.

The Sublocade was -- in 2018 was sponsored by Indivior.

Those are the ones that strike me in the moment.

Q. I have a question about the presentation listed as the Interface of Pain and Addiction --

A. Where are you?

Q. -- from 2002 in Nashua, New Hampshire.

Do you remember a group or a more specific location?

To whom was that presentation given?

MR. BLANK: Objection.
THE WITNESS: I don't recall.
QUESTIONS BY MS. GAFFNEY:
Q. Why do you think Joe Russell recommended you for the fifth vital sign presentation?
MR. BLANK: Objection.
THE WITNESS: I don't know. I had gotten to know him, and he knew that I was giving lectures on alcohol abuse.
QUESTIONS BY MS. GAFFNEY:
Q. At that point you had already given some lectures about chronic pain as well; is that correct?
A. Yes, I had.
Q. And how did your first lecture related to chronic pain come about?
A. A woman by the name of Seddon Savage, who was an addiction specialist at -- in the state of New Hampshire, asked me if I would give a presentation.
Q. Seddon Savage, is that --
A. S-e-d-d-o-n, S-a-v-a-g-e, Seddon Savage.

Q. And she was an addiction specialist.

Was she also an MD?

A. Yes. In anesthesiology.

Q. Okay. Turning to Exhibit B of your report is your materials considered. And we now also have the supplemental materials considered list from your counsel.

Taking the two together, the materials considered list and the supplemental considered list, do these two lists together identify all the materials that you considered in forming your opinion in this case?

A. And my 40 or 50 years of experience in addiction.

MR. BLANK: Sorry, Counsel, I don't think you've marked the supplemental list.

MS. GAFFNEY: Oh. Thank you.

(Hevern Exhibit 4 marked for identification.)

MR. BLANK: This will be 4?

MS. GAFFNEY: Uh-huh, Exhibit 4.

QUESTIONS BY MS. GAFFNEY:

Q. How did you determine what materials to note on the materials considered and supplemental materials considered list?

A. It was on -- the literature and other materials, those were the readings that I had done and the books that I had perused or actually read, or presentations that I read, and in creating my report referred back to them was what I -- was how it worked.

In terms of the materials considered, the -- and the supplemental materials considered, these were information that counsel provided to me.

Q. Just to clarify, which materials are you referring to as the ones that counsel provided to you?

A. Something called Gerard J. Hevern Supplemental Materials Considered, something called Topic and Materials Considered by Gerard Hevern.

Q. Okay. Distinguishing that from the page that starts with literature and other materials?

A. That's what I'm saying.

Q. Got it. Thank you.

And did you ever ask counsel for any specific materials?

A. No.

Q. With respect to the materials provided by counsel, did you rely on any of these materials for your report?

A. No.

Q. Supplemental materials considered list, these are all things that you considered after submitting your report, 19 expert reports, seven interrogatory responses and one deposition transcript.

Why did you review these materials after submitting your report?

MR. BLANK: Objection.

THE WITNESS: I quickly reviewed them. I read Steven Cohen's and Richard Del La Garza pretty much thoroughly and Catherine Keyes. All the others I just kind of perused.

I wanted to essentially see what was being said by different folks.

MR. BLANK: A short break would

be useful.

MS. GAFFNEY: Short break. We can do that.

MR. BLANK: Thank you.

VIDEOGRAPHER: We're going off the record at 11:27 a.m.

(Off the record at 11:27 a.m.)

VIDEOGRAPHER: We are back on the record at 11:41 a.m.

QUESTIONS BY MS. GAFFNEY:

Q. Dr. Hevern, let's go back to your materials considered list. I have a few questions about the materials provided to you by counsel.

Your list includes two MDL-produced documents. Let's see, I think -- not the supplemental materials considered list --

A. This stuff here?

Q. Yes, right at the top.

A. Oh, I'm sorry.

Q. What are those two documents?

A. I actually don't know what they are.

Q. Safe to say they did not inform

your opinion in your report?
MR. BLANK: Objection.
THE WITNESS: Correct.
QUESTIONS BY MS. GAFFNEY:
Q. And how about the Ohio Board of Pharmacy extract format description, what is that document?
A. I briefly reviewed it, but I did not -- it was not anything I used for my opinion.
Q. Okay. Do you recall what it was?
A. Not at this point.
Q. And now turning to the literature and other materials list in that same Exhibit B.
A. Okay.
Q. You testified that this is the list you put together based on readings that you had done or presentations you had read in creating your report; is that correct?
A. Correct.
Q. So is it your testimony that you've reviewed all of the materials on this list carefully?

A. Yes.
Q. And you believe that all of the materials listed here are reliable and support your opinions?
MR. BLANK: Objection.
THE WITNESS: Yes.
QUESTIONS BY MS. GAFFNEY:
Q. Were any of the materials on this literature list provided to you by counsel?
A. No.
Q. How did you go about identifying the materials on this list?
Did you run searches of the literature, or how did you do that?
A. Some I already possessed in my physical possession and others I did Google searches or med -- Medline searches.
Q. What sort of search terms did you use for those online searches?
A. Multiple.
Q. For example?
A. Opioid and pain management, ASEM definition of terms, DSM-V cat -- you know, DSM-V categories for the description of

addiction, things like that.

Q. Did you have any help performing that research?

A. No.

Q. Do you remember when you did those searches?

A. Some of them began in April. Many of them began in April when I started to look.

And -- almost all of them were in April. Some of them may have been in early May as I was concluding my report.

Q. Before the break, you had mentioned Purdue representative Joe Russell who would come to your office two to three times a year?

A. Yes.

Q. Would he be promoting certain products when he would call on your office?

A. He would be.

Q. And what products or product were those?

A. It was OxyContin.

Q. Did representatives of any other pharmaceutical manufacturers call on

your office?

A. Yes.

Q. Which manufacturers?

A. Many. Many.

Q. Any that stand out in your memory?

A. Not in particular.

Q. In these many sales calls, did any representatives ever provide lunch for you or your staff?

A. That was the -- that was the format that we used at our office.

Q. When you say "that was the format that you used," can you describe that for me?

A. Yes.

The lunchroom was the only large room that we had, and so if my -- if they were going to do a presentation and my staff was there, they needed to provide them lunch.

Q. So the format would be that the sales representative would provide lunch and then during that lunch make a presentation about a product; is that fair?

A. Correct.
Q. Do any of those product presentations stand out in your recollection?
MR. BLANK: Objection.
THE WITNESS: There were -- there were so many drugs that were new in medicine that none of them stand out particular.
QUESTIONS BY MS. GAFFNEY:
Q. In your recollection, have you ever prescribed a product based on what you learned from some of these presentations?
A. They assisted me in knowing. Most of the time I relied upon the PDR.
Q. Are you familiar with the phrase "key opinion leader" or KOL?
A. Only since I've read it in some depositions. But not depositions. I mean expert -- I didn't -- I haven't read any depositions, but I mean in the expert witness material that I read.
Q. How about the phrase "speakers bureau"? Are you familiar with that?
A. Yes, I am.
Q. Did you ever serve on a

speakers bureau for a drug manufacturer?

A. I have.

Q. Which manufacturer?

A. Lilly.

Q. Any others?

A. I -- well, I did presentations that was supported by Purdue but not in the speaker bureau format.

I did presentations for whoever produces Butrans, and I don't know who that is.

And I did presentations for Sublocade, which was Indivior.

Q. In the presentations supported by Purdue that you mentioned, were those with respect to a particular product?

A. No, those were some of the items that you identified out of all of the material produced by me.

Q. How about the -- you testified that you were on a speakers bureau for Lilly?

A. Yes.

Q. And was that with respect to a particular product?

A. Yes.

Q. Which product was that?
A. Prozac for the use of the dysphoric dysfunction, which you know as premenstrual syndrome, or may know as premenstrual syndrome.
Q. Have you received payment for these talks that you've participated in?
A. I have.
Q. Do you know how much payment you've received over the years?
A. Probably less than $10,000.
Q. And how did your involvement on the presentations supported by Purdue come about?
A. My recollection was that -- my recollection was that either Joe Russell or a member of the CME committee would contact me.
Q. Have you ever served as a consultant to a pharmaceutical company?
A. I went to two -- I don't know what you would call them, but two weekend retreats, I guess, to talk about -- in a group setting on two occasions.
Q. When did those take place?
A. 2014-ish.

Q. Both of them in that time frame?

A. I believe so.

Q. And did both of them involve the same pharmaceutical company or were they different?

A. I think the same one. So one was clearly a Purdue product, and the other one I think might have been a Purdue product, but I'm not certain.

Q. What were the two products?

A. One was Hysingla, and the other was looking at opioid -- or abuse-deterrent properties that were being considered by Purdue.

Q. So what was the nature of what you were asked to do on these weekend retreats?

A. Be a part of roundtable discussions.

Q. And were you compensated for your participation in these discussions?

A. Yes. Yes, I was.

Q. How much were you compensated?

A. They paid for my transportation

and my hotel arrangements and a daily fee of maybe a thousand dollars. I'm not certain.

Q. So with these products you've been involved with, Prozac, Butrans, Sublocade, Hysingla, have you ever recommended any of these products to colleagues?

A. Prozac I did. Hysingla I did -- no, not Hysingla. I mean Sublocade I did. I did not, you know, do any support of Hysingla.

Q. Okay. So I have a list I'm just going to run through.

Have you ever consulted for or done any work for Endo?

A. No.

Q. Insys?

A. Excuse me?

Q. Insys?

A. I don't -- no.

Q. Teva?

A. No.

Q. Mallinckrodt?

A. No.

Q. Allergan?

A. No.
Q. Janssen?
A. No.
Q. Or Johnson & Johnson?
A. No.
Q. Okay. AmerisourceBergen?
A. No.
Q. Anda?
A. No.
Q. Cardinal Health?
A. No.
Q. CVS Pharmacy?
A. No.
Q. Discount Drug Mart?
A. No.
Q. HD Smith?
A. No.
Q. Health Mart Systems?
A. No.
Q. Henry Schein?
A. No.
Q. McKesson?
A. No.
Q. Rite Aid?
A. No.

Q. Walgreens?
A. No.
Q. Walmart?
A. No.
Q. Okay. Thank you.
Do you have any personal relationships with any current or former employees at any of the drug manufacturers we've been discussing?
A. No.
Q. You mentioned a moment ago with respect to the Purdue presentations you participated in that you were contacted by Joe Russell or maybe a representative from a CME committee?
A. Correct.
Q. The CME committees, do you remember what organization those CME committees belonged to or --
A. Well, Lawrence General was one. The VA system was the other. Those are the two that I -- but those would be the things that I can recall.
Q. Okay. And in those two examples -- say, for example, you were

contacted by someone working on the CME committee for the VA, when did you learn that it was -- the presentation you were giving was sponsored by Purdue?

A. At the time that it was booked.

Q. And you said that you prepared the presentation materials that you would use?

A. Yes.

Q. Did Purdue review those at all?

A. No.

Q. So turning now to your report itself, you testified earlier that you didn't have any assistance in drafting your report; is that correct?

A. Correct.

Q. So every word and citation in the report you drafted?

A. Yes.

Q. Okay. Can you summarize for me in your own words the opinions that you're offering in this report?

MR. BLANK: Objection.

THE WITNESS: In general that addiction has been a chronic problem

in our society; that factors that contribute to addiction include underlying mental health problems, family history, social and environmental events, biological issues of the individual; and that the mental health system was not adequate to deal with the burgeoning problems that were occurring.

QUESTIONS BY MS. GAFFNEY:

Q. Thank you.

When would you say you formed these opinions?

A. They've been formed over the 40 to 50 years of my work, and the opinions about this process -- or the opinions about this paper really was the culmination of some of the reports that I gave in 2016 and 2018.

Q. And what are those reports in 2016 and 2018 you're referring to?

A. They're on my CV, and they are essentially the same presentation that I gave that began with -- well, actually 2017, with Management of Chronic Pain and Coexisting Disorders; 2018, the presentation I gave to

the New Hampshire Academy of Family Practice and to the American Academy of Family Practice national conference for residents in 2018.

Q. So looking back at the summary of opinions you just went through, addiction being a chronic problem in society, various factors contributing to that including mental health, social context, family, environmental and biological context of the individual, and then the mental health system not being adequate to address these issues, are there other opinions that you're -- you would summarize as opinions you're offering in your report?

MR. BLANK: Objection.

THE WITNESS: My report also includes issues of the availability of takeback components of medications.

The -- would be what I would say.

QUESTIONS BY MS. GAFFNEY:

Q. Are you offering any opinion in this case on the efficacy of opioids for chronic pain?

MR. BLANK: Objection.

THE WITNESS: That's not what I was asked, you know, to comment on.

QUESTIONS BY MS. GAFFNEY:

Q. Okay. So just to clarify that, it's not an opinion you're offering in this case?

A. That's correct.

Q. And, Dr. Hevern, you understand that one of the purposes of submitting your expert report is to disclose to the other side and the Court all of the opinions you will be offering in the case and then the support for those opinions in advance of trial; is that correct?

A. I do.

Q. So you don't intend to offer any opinions that are not put forth in your expert report at trial; is that also correct?

A. Not unless something new comes up.

Q. And in terms of understanding the bases for your opinions, are all of the materials that you would consider a basis for your opinions, in addition to your clinical

experience, provided in the materials considered list?

A. Yes.

Q. Your report also contains various footnotes.

Is that fair to say that where you've identified materials supporting a specific point in your report, you've provided that in a footnote?

A. Yes.

Q. Where you have provided footnotes in your report, is it your testimony that these contain all of the support for that particular point that they correspond to?

MR. BLANK: Objection.

THE WITNESS: Yes.

QUESTIONS BY MS. GAFFNEY:

Q. So for the statements that are in your report without specific footnotes, is it fair to say that the support for these statements is your clinical experience?

A. Yes.

Q. So looking at the section in your report called Historical Background,

Americans' Fascination with Drugs --

A. What page is that, please?

Q. It starts on the bottom of page 3.

A. Okay.

Q. Goes on to 4.

A. All right.

Q. And then the first full paragraph on page 4, you mention morphine and widespread incidence of addiction in the 1800s; is that right?

A. Correct.

Q. And you describe the occurrence of morphine addiction as related to the Civil War and war-related injuries.

What is the basis for that statement?

A. The research that I did for one of my papers and what is common knowledge for experts who have dealt with addiction.

Q. What is the research that you did for one of your papers?

Just to clarify what you just mentioned, what are you referring to there?

A. Hold on for a second.

Q. Uh-huh.

A. So in November 18, 2016, Drug Abuse and the Never-Ending Saga was the presentation I gave at the Elliot Hospital grand rounds. And during that period of time, I did all of the -- a significant amount of reading around the process of substance use disorder and some of the origins of that.

Q. And are those materials that you read listed in your materials considered list?

A. No, they're not.

Q. So in terms of what you're relying on as a basis for your statements in your report here in this paragraph, is your testimony that you're relying on materials that have not been disclosed?

MR. BLANK: Objection.

THE WITNESS: This knowledge is widely available to addiction specialists, and I was placing this information that is widely known to us into this report so that it would have context, historical context, of what

has gone on.

QUESTIONS BY MS. GAFFNEY:

Q. Do you recall what some of those materials that you read that are not disclosed here were?

MR. BLANK: Objection.

QUESTIONS BY MS. GAFFNEY:

Q. With respect to this history?

A. There is a -- there's a textbook I have at home that was written in probably 1909 that I have that I read through about morphine and morphine use.

Q. Have you read David Courtwright's book Drug Paradise?

A. No.

Q. Did you read David Courtwright's expert report?

A. No.

Q. It is listed on your materials considered list.

Did you consider it at all?

A. Not in the formation of my presentation here. I looked at this data afterwards.

Q. Are you intending to offer a

rebuttal opinion to his report with respect to the way you've characterized the morphine addiction of the late 1800s?

A. I'm not -- I was not asked to rebut anything.

Q. You also have the statement that "elixirs containing varying amounts of alcohol, opium, morphine, cocaine and heroin were sold without government regulation until 1920."

What is your basis for that statement?

A. The development of the Harris Act.

Q. Do you know when that legislation was enacted, sir?

A. 1920 -- well, between 1918 and 1921.

Q. Still looking at this description of the historical context in your report, you describe some issues with Vicodin, Darvocet and Percocet in the 1980s; is that correct?

A. Correct.

Q. But your description of the

historical context does not note any other prescription opioid abuse.

Why is that?

A. Because in the 1990s when I was running the chemical dependency unit at the CMC, those were the drugs that we were detoxing.

Q. And in the late 1990s and early 2000s, to your knowledge, was there -- were there any issues with prescription opioid abuse?

MR. BLANK: Objection.

THE WITNESS: I was no longer running the chemical dependency unit. I was an independent practitioner at that time.

QUESTIONS BY MS. GAFFNEY:

Q. And as an independent practitioner at that time, were you aware of any issues with prescription opioid abuse?

MR. BLANK: Objection.

THE WITNESS: I was reading about that. I was not personally or professionally involved in the management other than a

consultative -- selective consultations, and that's my knowledge.

QUESTIONS BY MS. GAFFNEY:

Q. But you were reading about the existence of issues with prescription opioid abuse at that time?

A. Yes.

Q. Is there a reason why you did not include it in your history section in your report?

A. Ask the question again? Say that one more time?

Q. Is there a reason why you do not include prescription opioid abuse in the late 1990s and early 2000s in your history section of your report?

MR. BLANK: Objection.

THE WITNESS: I did.

QUESTIONS BY MS. GAFFNEY:

Q. Can you point me to that?

A. Yeah. Fifth paragraph, "Thus dentists, oral surgeons, orthopedic surgeons were prescribing Vicodin, along with other prescription opioids, including Darvocet and

Percocet."

Q. Okay. And this starts with "around the same time."

Is your testimony that this is intended to describe the late 1990s and early 2000s?

Because the prior paragraph describes the 1980s.

A. Correct. And '80s transitioning into the '90s, this was what was happening.

Q. Okay. And were you aware of issues with OxyContin abuse in the late 1990s and early 2000s?

MR. BLANK: Objection.

THE WITNESS: Not specifically.

QUESTIONS BY MS. GAFFNEY:

Q. Were you aware that there were Congressional hearings about OxyContin abuse in the early 2000s?

A. In the early 2000s? No, I did not. I don't recall that.

Q. It's around that time that you were giving presentations for Purdue, correct?

MR. BLANK: Still in the early 2000s?

MS. GAFFNEY: In the early 2000s, yes.

THE WITNESS: Let me take a look.

I was giving lectures around abuse and diversion and drug impact on society, but I did not read any Congressional hearings is what I'm trying to say to you.

QUESTIONS BY MS. GAFFNEY:

Q. You were giving lectures around abuse and diversion and drug impact on society.

What sort of abuse and diversion and drug impact are you referring to?

A. Issues of prescription drugs that were being diverted. That was the -- you know, and how they were presenting to emergency rooms and to -- and to office -- and to private offices.

Q. And were you aware of any issues with OxyContin in particular being

diverted at that time?

A. Yes.

Q. Is there a reason why you did not note that in your expert report, in your historical summary?

MR. BLANK: Objection.

THE WITNESS: No.

QUESTIONS BY MS. GAFFNEY:

Q. You state that in the 2000s -- it's on page 5, the second -- or the first full paragraph, "The illegal drug cartels that were supplying heroin began to lace it with fentanyl."

What's your basis for that statement?

A. Two general sources: what was being reported on TV and radio and what was being produced in literature surrounding drug overdoses in CDC materials.

Q. Is the literature that you mentioned included in your materials considered list?

A. I'm sorry?

Q. The literature that you just mentioned, is that included in your materials

considered list?

A. It would be with the CDC reports.

Q. Okay. And as you don't have a footnote citation for this paragraph, can you point me to the sources that you're relying on for this paragraph?

A. Some of it would be in number 5, 2002 to 2013, some of the CD -- drug abuse and government, and then there are different ones throughout here from CDC's reports.

Q. Can you point me to the particular sources in the -- this is for the statement about fentanyl appearing in the 2000s.

A. They -- here they are. Okay. In the footnotes -- here it is. Centers for Disease Control Prevention FastStats retrieved from the CDC -- that's on tobacco -- the Centers for Disease Control and Prevention for drug overdoses are the two locations that I would have gone to. So those would -- those would begin to give me information about the -- those components of

really what was happening.

I'd have to go through all of these. I'm quickly reading through them.

So those would be two of the sources.

Q. So the two CDC sources - one, as you noted, is about tobacco, and the other, the title is "US Opioid Prescribing Rate Maps" - how do those support the statement of fentanyl appearing in the 2000s by way of illegal drug cartels?

A. The other source was the National Institute of Drug Abuse, drug trends 2015.

Q. Okay. And just going back to my question about the two CDC sources.

A. Yes.

Q. The one about tobacco and the other one about opioid prescribing rates, how do those support the statement of fentanyl appearing in the 2000s by way of illegal drug cartels?

A. There were two -- two components what I said to you is the first one is that was -- that became knowledge

through releases on TV and on radio from the CDC about those things, and that was being published in different alerts from them.

So those are not noted, but they were noted by TV and radio. Those specific items would have referred to those in the documentation.

Q. The CDC FastStats on tobacco?

A. That would be on the tobacco one.

There -- it would be for the, you know, opioid prescription rates and retrieve what they -- those would be items that would be listed in the CDC reports.

Q. With respect to fentanyl coming through illegal drug cartels?

A. I believe so.

Q. Okay. So as we discussed a few minutes ago, disclosing the materials considered, the materials that are forming the bases for your opinion, is important to the plaintiffs in litigation as well as the Court.

You've submitted an expert report and materials considered list. You

have stated that the statements in your report that do not have footnote citations are supported by your clinical experience.

So I'm just trying to understand the support for the statement in this paragraph in particular about illegal drug cartels in the 2000s.

Is it your testimony that your knowledge -- the basis for this statement is what you saw on TV and heard on the radio, in addition to the two CDC documents here as well as the National Institute on Drug Abuse publication from 2015?

MR. BLANK: Objection.

THE WITNESS: Yes, and additional readings from CDC reports. So it's a combination of all of those things.

QUESTIONS BY MS. GAFFNEY:

Q. Dr. Hevern, to the extent that there are additional readings that you are relying on as a basis for your expert opinion, I would ask that you disclose those sources.

A. Okay.

MR. BLANK: When you get to a good breaking point, it's about 12:30, so let us know if you're close.

MS. GAFFNEY: Sure. This is a good breaking point now.

MR. BLANK: Okay.

VIDEOGRAPHER: We're going off the record at 12:29 p.m.

(Off the record at 12:29 p.m.)

(Hevern Exhibit 5 marked for identification.)

VIDEOGRAPHER: We're back on the record at 1:24 p.m.

QUESTIONS BY MS. GAFFNEY:

Q. Welcome back, Dr. Hevern.

A. Yes.

Q. Your counsel provided us with an amended page 4 of your complaint {sic}, which we'll mark it as Exhibit 5.

A. Yes.

Q. What was the change you made on this page?

A. Excuse me. On the top line, the amended version says, "By comparison, there's approximately 47,000 opioid-related

deaths each year in 2016, 2017."

Q. Okay. And what was the change?

A. It had read, "By comparison, there was approximately 47,000 prescription opioid-related deaths each year in 2016 and 2017."

Q. Okay. Thank you.

And how did you come to believe this change was necessary?

A. When I was reading the transcript -- not transcription -- excuse me, my report last night, I looked at it and I said, "That's wrong."

Q. Okay. So you carefully reviewed page 4, clearly.

You carefully reviewed the rest of your report as well, I take it?

A. Yes, I have.

Q. Any other changes to your report?

A. No.

Q. Okay. Thank you.

On page 5 of your report, right before the heading Addiction, that last paragraph in the history summary of your

report, you state that, "History teaches us that there has always been, and likely always will be, a segment of the population that is susceptible to developing drug-seeking behavior, and the predominant drugs of abuse will vary or rotate over time."

Did I read that correctly?

A. Yes.

Q. And what is the basis for your statement here?

A. Both my clinical observation and management of patients in -- or who had addiction, the report from the drug abuse and government publication that I list.

Q. In footnote 5?

A. That's what I meant, uh-huh.

Q. Okay.

A. That's what I meant, I'm sorry.

Q. Is there anything else on your materials considered list that you're relying on for that statement?

A. None.

Q. And this citation in footnote 5 notes that, "Between 2002 and 2013, there was a remarkably stable percentage of the

population, between 8 to 10 percent, that abused illicit drugs, representing a persistent population susceptible to developing substance abuse."

Did I read that correctly?

A. Yes.

Q. And how do you define the term "abuse"?

Here it's used, "abuse illicit drugs," and then you reference substance abuse.

A. Substance -- they're interchangeable. Substance abuse and abuse of illicit drugs are generally interchangeable.

Q. And what does "abuse" mean in the context of drug use?

A. Misusing a drug or alcohol and becoming somehow impaired but not becoming addicted to it.

Q. Is there a difference between misuse and abuse?

A. Technically, I don't think so.

Q. And then how would you define addiction?

A. Addiction, it's -- it's in my definition here. Should I read it? Page 6, second paragraph.

Q. No, that's fine to point to this paragraph.

A. Okay.

Q. Okay. And then in your own words, how does that differ from dependence?

A. Dependence is an outcome of the use of many different kinds of medications.

An addiction is a misuse of those medications in a manner that creates craving and difficulties for the individual.

Q. And in your experience, are there people who are dependent on drugs but not abusing them?

A. That's a challenging question. Many different categories of drugs you can become dependent upon.

I'm assuming you're talking about opioids?

Q. That's a fair assumption, but actually my question was more general.

So what does it mean to be dependent on drugs, whether it's opioids or

another category?

A. Oh, dependency would mean that at the -- if you abruptly stop the medication, you'll have symptoms or a negative outcome.

Q. Okay. So if I understand correctly, it is possible to become dependent on drugs without abusing them; is that correct?

A. Correct.

Q. And conversely, is it also possible to abuse drugs without becoming dependent on them?

A. Yes.

Q. So going back to footnote 5, this percentage of the population susceptible to developing substance abuse, the 8 to 10 percent you cite here, that does not take into account a percentage of the population that may be dependent on -- well, in this context, dependent on opioids but not abusing them; is that correct?

MR. BLANK: Objection.

THE WITNESS: Could you ask that question again? I lost --

QUESTIONS BY MS. GAFFNEY:

Q. Uh-huh.

You represent in footnote 5 that there's a stable percentage of the population, between 8 to 10 percent, that is susceptible to developing substance abuse.

And as we were just discussing, substance abuse and dependence are different concepts.

A. Substance abuse and dependence --

Q. Dependence --

A. -- are different concepts, yes.

Q. So this -- is it correct to say that this 8 to 10 percent proportion of the population does not take into account individuals who are dependent on, for example, prescription opioids but not abusing them?

A. I'd want to reread the entire component of it, but that's how I would interpret that.

Q. Okay.

A. Hold on for just one second.

Thank you.

Q. And you said dependency would mean that if you abruptly stop the medication, the patient would have symptoms or a negative outcome.

Have you seen that happen in your practice with patients who are dependent on opioids?

A. Yes.

Q. And in your experience with these patients, what has happened -- well, first of all, to back up.

What was the reason for the abrupt stop in medication that led to this outcome that you've seen in your practice?

MR. BLANK: Objection.

THE WITNESS: These are people who have been referred to me whose medications have been stopped by other physicians.

QUESTIONS BY MS. GAFFNEY:

Q. In your own practice, as we spoke about this morning, you do not generally abruptly stop patients' opioid medications; is that correct?

A. That's correct.

Q. But you do have clinical experience with patients who have had those medications abruptly stopped by other physicians and then referred to you for management of the symptoms they're experiencing?

A. That's correct.

Q. And what do you do in that situation to assist patients who are experiencing -- fair to say they're experiencing withdrawal what we're discussing?

A. Yes.

Q. How do you assist patients in that -- who are experiencing withdrawal?

A. How do I --

MR. BLANK: Objection.

THE WITNESS: I apologize.

How do I what?

QUESTIONS BY MS. GAFFNEY:

Q. Assist patients --

A. Oh, assist, I'm sorry.

Q. -- who are experiencing withdrawal?

A. There are two approaches that I

can take. The first is to treat them with a combination of medications that treat symptoms. The second is to introduce then the use of buprenorphine or Suboxone as a medically assisted treatment for substance abuse disorder.

Q. And the first option, the combination of medications that treat symptoms, what's the combination of medications you would use?

A. The names of medications, or what would you -- or the categories?

Q. Or the categories, yeah.

A. Well, one is to help prevent nausea. One is to help prevent diarrhea. One is to help prevent the gooseflesh skin and the sweating that's accompanied by that. And depending on how emotionally agitated, you would use a medicine to reduce anxiety.

Q. And what are the factors you consider with a patient in terms of choosing that first option of treating the withdrawal symptoms versus initiation of buprenorphine or Suboxone?

A. The choice would be based upon

whether or not the patient is -- has demonstrated opioid addiction, and that's why they're withdrawing versus -- and if so, I would then offer them the use of Suboxone to treat their addiction and put them in what we call a medically-assisted treatment.

Q. Just going back, you said if they demonstrated addiction and that's why they're withdrawing versus -- what's the end of that sentence? Versus...

A. Oh, if they are -- I have to read the -- I apologize. I don't mean to --

Q. Do you want me to reread it?

A. If you wouldn't mind, I'll pick it up from that point.

Q. So you said, "The choice would be based upon whether or not the patient has demonstrated opioid addiction and that's what -- why they're withdrawing versus" --

A. That the medication was abruptly stopped by another physician because they were no longer prescribing that medication to them.

Q. Am I correct to understand meaning that it's a situation of dependence

but not addiction?

A. That's what I'm trying to indicate.

Q. I take it you have a waiver to prescribe buprenorphine; is that right?

A. Correct.

Q. When did you obtain that waiver?

A. I believe in 2013.

Q. In your report you discuss the concept of pseudoaddiction.

Is that something that you would say you've seen in your practice?

A. Yes.

Q. And in those instances of pseudoaddiction in your practice, would you address the phenomenon of pseudoaddiction by increasing the opioid dose?

A. I address that in both inpatient and outpatient settings, and the way to address it is by adjusting medications, either frequency or amount, or changing the medication altogether.

Q. And when you say "adjusting either frequency or amount," can you

elaborate on what that looks like?

MR. BLANK: Objection.

THE WITNESS: In an inpatient setting, they may be giving a medication every eight hours when they should be giving it every four hours. And so I write the order to be every four hours, so that's a frequency.

And the other is that they're giving a low dose of medication, and you increase the actual milligram per dose that they're getting, but the frequency or the interval between each dosing remains the same.

QUESTIONS BY MS. GAFFNEY:

Q. How many patients would you say you have treated with -- that exhibit pseudoaddiction?

A. A few hundred probably.

Q. And how do you know in those situations that it is pseudoaddiction and not addiction?

A. Most often because they respond to my adjustments in their medication. They -- the symptoms that they're having,

they are resolved.

Q. And in your experience, could a patient be exhibiting signs of addiction and still have those behaviors resolved by adjustments in medication?

A. The symptoms would abate, but addiction would move them to misuse that medicine again.

Q. Okay. Looking at page 7 of your report --

A. Okay.

Q. -- underneath the heading, "Opioids Prescribing Versus Opioids Abuse," you have the statement, "For patients with no history of substance abuse or mental health issues, the risks -- the risk of iatrogenic addiction is low."

What is the basis for this opinion?

A. Data that I've read through different reports.

Q. And in this paragraph you have two footnote citations.

Is that some of the reports you're referring to?

A. I don't know if those explicit ones are the ones that I'm referring to -- I'd have to reread the article -- but those data are in the handout.

I'd have to relook at that explicit form to say -- to link those two precisely.

Q. Okay. So just to understand -- so as you sit here today, can you point me to the -- any sources that you're relying on for the statement that "the risk of iatrogenic addiction is low for patients with no history of substance abuse or mental health issues"?

MR. BLANK: Objection.

THE WITNESS: What I can say is it's -- it's in -- I can't select in the moment through these 50 or 60 references in the moment, you know, that reference, but it would be in here.

QUESTIONS BY MS. GAFFNEY:

Q. So your testimony is that the basis for this opinion exists in your materials considered list, but you did not provide a footnote for it?

MR. BLANK: Objection.

THE WITNESS: Well, the footnote is number 7, is what I'm saying to you, is what I'm referencing.

Are there other references within the list? I'm saying there probably is, but I'm not going to be able to pull them out and begin to finger point them to you.

QUESTIONS BY MS. GAFFNEY:

Q. When did you form this opinion?

A. Which opinion?

Q. That for patients with no history of substance abuse or mental health issues, the risk of iatrogenic addiction is low.

A. When I began to look at this issue back in probably the early '90s, maybe the late '80s.

Q. Do you consider yourself to be familiar with the literature on this issue?

A. Yes.

Q. And is it your opinion that all of the literature on this issue uniformly

supports your statement?

MR. BLANK: Objection.

THE WITNESS: There's a wide range of -- there's a wide range within the definition of addiction -- of iatrogenic addiction in the literature.

QUESTIONS BY MS. GAFFNEY:

Q. So when you say "there's a wide range" in the literature, does that mean it's your understanding that the literature does not uniformly support your statement?

A. It supports two different data points. I'm talking about no history of substance abuse or mental health issues, the iatrogenic issue is low.

There are other data that do not exclude those -- there are other pieces of data or data that doesn't exclude -- exclude those, and so the rates are higher in that -- in that population.

Q. Okay. But just for the way that you've expressed it here, which is limited to the population for patients with no history of substance abuse or mental

health issues, is it your opinion that the literature existing on that question uniformly supports your statement that for those patients the risk of iatrogenic addiction is low?

MR. BLANK: Objection.

THE WITNESS: Yes.

QUESTIONS BY MS. GAFFNEY:

Q. The wide range that exists in the literature that you mentioned, what is the range?

A. It's as, believe it or not, low as less than 1 percent to as high as -- I've seen in the 30s, 30 percent. Commonly said between 1 and 20 -- and 20 percent.

Q. Keep going to page 9 of your report.

A. Sure.

Q. Sorry, just give me a second. The inside might be wrong.

Okay. Here it is at the top of the page. "The current problem of opioid misuse and abuse seems to be part of a much larger and complex substance abuse problem driven primarily by powerful socioeconomic

factors rather than by any specific substance of abuse."

What do you mean by "powerful socioeconomic factors"?

A. The rates of poverty, rates of identification of socioeconomic factors, are primarily poverty and, interestingly enough in some instances, is wealth. In some instances it turns out to be complacency within the context of what's going on, and in some instances it's the outcome of -- those are -- those are the instances of what you're talking -- what exist.

Q. And to understand the basis for your opinion here, you have cited -- you have two footnotes here citing two different articles, and I take it that these are -- form part of the basis for your opinion here?

A. Yes.

Q. Okay. Are there any other bases for this opinion?

A. Again, a lot of it is based upon my observation, you know, in caring for a lot of patients over -- you know, tens of thousands of patients over 40 years.

Q. Okay. Keep going through your report.

On pages 10 through 11 of your report, you discuss that states were slow to adopt recommended measures to curb opioid abuse.

Is that a fair summary?

A. Yes.

Q. And that they've also gone too far in some respects?

A. Yes.

Q. What are some of these recommended measures to curb opioid abuse?

A. There have been, if not exactly here, three of them that would be noted. The first one was the development of something called the PDMP, or Prescription Drug Monitoring Program, the second one was the ability to have a drug takeback, and the third has been the development of these now commercially available bags that you can pour extra medicines in that make them unusable, are three off the top of my head without rereading all of my other components here.

Q. It's on page 11 that you say

that "in some cases, however, the pendulum has swung back too far."

What do you mean by that, "the pendulum has swung back too far"?

A. There are patients who would be considered, quote, legacy patients, unquote, on opioid-based pain medications, and their medications are being discontinued, and the outcome is a negative outcome for the patient.

Q. What sort of negative outcome for the patient?

A. From a reduction in functional capacity and activity, increasing pain, and an increasing suicide rate.

Q. And is the primary basis for your opinions in this section your clinical experience?

A. Clinical experience, and there are some references in here as well to Volkow, V-o-l-k-o-w. Yeah, New England Journal of Medicine and...

Q. Any others that you would point to as forming the basis for your opinions here in this section?

A. There are a number -- there are a number of others, I don't -- that are in here that I don't want to -- I mean, they're in here and I could -- I could find, but it will take some time to do that.

The other one is -- how do you pronounce that? Oquendo, O-q-u-e-n-d-o, and Volkow, V-o-l-k-o-w. Passik, the two Passik articles, Dowma.

So there are a series of articles in here that support that concept.

Q. Okay. Thank you.

When did you form this opinion?

MR. BLANK: Objection.

THE WITNESS: The opinion --

QUESTIONS BY MS. GAFFNEY:

Q. Just to clarify, the opinion we were just discussing with respect to these measures -- the pendulum swinging back too far.

A. In the last two years.

Q. Turning to the section of your report on neonatal abstinence syndrome.

A. Yes.

Q. You state that "there's little,

if any, evidence that babies with neonatal abstinence syndrome born to mothers who receive prescription medications during pregnancy and were medically managed by an obstetrician have lingering effects or disabilities, nor is there any evidence that there's an increased cost of treatment."

What's the basis for that statement?

A. That's directly out of a -- out of an article, that's number one.

Number two is that the manage -- when -- when women who are pregnant are known to have use of opiate-based pain medications for whatever reason and the obstetrician is supervising that process, they also then alert then the neonatal units of what's happening, and so there's a -- there's a more intensive kind of observation of that process.

Often those mothers deliver on due dates at the expected date of confinement, and there are less premature births. And so that's the basis of really what goes on.

Q. Okay. So in large part coming from your clinical experience?
A. Correct.
Q. Okay. And you mentioned an article.
What article is that?
A. Well, hopefully I included it here.
Okay. I don't see -- oh, here it is. One of them is "Opioid Use Disorder and Rise in Pregnant Women, Practical Pain."
That was one of the articles.
Q. Are there any others on your materials considered list?
A. Not that I noted.
Q. Do you consider yourself familiar with the literature with respect to changes in the neonatal brain following prenatal opioid exposure?
A. I'm not familiar with that literature.
Q. You state that there isn't any evidence that there's an increased cost of treatment for these babies with neonatal abstinence syndrome whose mother has been

managed by an obstetrician, but you also state that the infants are immediately entered into the NICU.

Would you agree that NICU care comes with an increased cost compared to care outside of the NICU?

A. It probably does, uh-huh, yes.

Q. Well, would you agree that NICU care -- does it bring any risk, increased risk, such as risk of infection?

A. I don't know that literature. I can't comment on that.

Q. What's the basis for your statement that women actively using illicit drugs, that many of them have more than one unexpected pregnancy?

A. More than one unexpected pregnancy?

Actually, it's women who are using illicit and polysubstance abuses, they tend to have unintentional pregnancies.

Q. I'm just looking at the -- at a line here. It says, "Without the needed ongoing recovery support through counseling and medication-assisted treatment, many of

these women have more than one unexpected pregnancy."

A. Yes, that also is true.

What happens is they do not achieve effective protection against pregnancy.

Q. And what's the basis for that statement?

A. Both some clinical observation as well as reading literature and discussions within the context of some of the different hospital committees that I am a part of.

Q. The literature that you mentioned, is it on the materials considered list?

A. I'm not -- I don't think that is.

Q. And the following sentence, "Most, if not all, of these children become wards of the state, being raised either by grandparents or foster parents," what's the basis for that statement?

A. The outcomes of the children that I've seen who are -- whose mothers are actively using and the outcomes of what I see

in practice currently. The number of children that are being raised by their grandparents is profound.

Q. Okay. So your clinical practice is the basis for that?

A. Yes.

Q. Okay. Dr. Hevern, would you say that you have been personally affected by the opioid crisis?

A. What do you mean?

Q. Do you feel that the opioid crisis has affected you personally in any way?

A. I have not personally been affected by it.

Q. Has it affected you professionally?

MR. BLANK: Objection.

THE WITNESS: Yes.

QUESTIONS BY MS. GAFFNEY:

Q. How so?

A. A lot more work.

Q. The type of work you're referring to, is it the work you do treating patients with addiction or --

A. Correct.
Q. Outside of your work with Dechert in this case, have you ever worked with any of the other law firms involved in this litigation?
I can run through the list if --
A. You don't have to run through the list. The answer is no.
Q. Are you familiar with any of the experts working with the plaintiffs in this litigation?
A. What do you mean?
Q. Do you know any of them professionally or personally?
A. No.
Q. Same question for any of the other defense experts?
A. I've never met them.
Q. Do you communicate with any of the other experts offering reports on behalf of the defense in this litigation?
A. No, I have not.
MS. GAFFNEY: We can take a short break.

VIDEOGRAPHER: We're going off the record at 2:10 p.m.

(Off the record at 2:10 p.m.)

VIDEOGRAPHER: We're back on the record at 2:21 p.m.

MS. GAFFNEY: Dr. Hevern, I don't have any further questions. I understand your counsel --

MR. BLANK: Thank you, Counsel.

So I will have just one or two questions. So I'm going to move over to the other side of the table so you continue to look in the right direction. Give me a moment.

VIDEOGRAPHER: Do you want to go off the record?

CROSS-EXAMINATION

QUESTIONS BY MR. BLANK:

Q. Dr. Hevern, just two follow-up areas of questions.

Earlier today Ms. Gaffney asked you about the fees that you received for various speaker engagements over your career; is that right?

A. That's correct.

Q. I believe you said something in the range of $10,000?
A. Yes, correct.
Q. Was that a total amount over a period of time?
A. It's probably total amount over the 20 years that I've spoken.
Q. Okay. And so for a typical engagement, what are the fees for just a one-time -- sorry, a single engagement?
A. From $350 to $1,500.
Q. And earlier today Ms. Gaffney also asked you a number of questions about presentations that you've made and speaker bureau practices.
Do you recall that?
A. Yes.
Q. And I believe that one of the presentations you said you made was on Butrans.
Do you recall that?
A. Yes.
Q. And was that in a speaker bureau format?
A. That was a speaker bureau

format, correct.

MR. BLANK: Okay. I don't have anything further.

MS. GAFFNEY: No further questions.

MR. BLANK: We're off the record.

VIDEOGRAPHER: Okay. This concludes the videotaped deposition of Gerard Hevern, MD.

We are going off the record at 2:23 p.m.

(Deposition concluded at 2:23 p.m.)

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CERTIFICATE

I, CARRIE A. CAMPBELL, Registered Diplomate Reporter, Certified Realtime Reporter and Certified Shorthand Reporter, do hereby certify that prior to the commencement of the examination, Gerard Hevern, MD, was duly sworn by me to testify to the truth, the whole truth and nothing but the truth.

I DO FURTHER CERTIFY that the foregoing is a verbatim transcript of the testimony as taken stenographically by and before me at the time, place and on the date hereinbefore set forth, to the best of my ability.

I DO FURTHER CERTIFY that I am neither a relative nor employee nor attorney nor counsel of any of the parties to this action, and that I am neither a relative nor employee of such attorney or counsel, and that I am not financially interested in the action.

Carrie A. Campbell

CARRIE A. CAMPBELL,
NCRA Registered Diplomate Reporter
Certified Realtime Reporter
Notary Public
Dated: June 14, 2019

INSTRUCTIONS TO WITNESS

Please read your deposition over carefully and make any necessary corrections. You should state the reason in the appropriate space on the errata sheet for any corrections that are made.

After doing so, please sign the errata sheet and date it. You are signing same subject to the changes you have noted on the errata sheet, which will be attached to your deposition.

It is imperative that you return the original errata sheet to the deposing attorney within thirty (30) days of receipt of the deposition transcript by you. If you fail to do so, the deposition transcript may be deemed to be accurate and may be used in court.

ACKNOWLEDGMENT OF DEPONENT

I,_____, do hereby certify that I have read the foregoing pages and that the same is a correct transcription of the answers given by me to the questions therein propounded, except for the corrections or changes in form or substance, if any, noted in the attached Errata Sheet.

_____

Gerard Hevern, M.D. DATE

Subscribed and sworn to before me this _____ day of _____, 20 _____.

My commission expires: _____

Notary Public

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ERRATA

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LAWYER'S NOTES

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